STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155783	A. BUILDING 00 B. WING	08/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENLEAF LIVING CENTER	1201 E BEARDSLEY ELKHART, IN46514

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00093981 and IN00093860. Complaints IN00093981 and IN00093860 - Unsubstantiated due to lack of evidence. Survey dates: August 14, 15, 16, 17, 2011 Facility number: 002661 Provider number: 155783 AIM Number: N/A Survey team: Carol Miller RN, TL Honey Kuhn RN Julie Wagoner RN (August 15, 16, 17, 2011) Timothy Long RN (August 15, 16, 17, 2011) Christine Fodrea RN Census bed type: SNF: 43 Residential: 31 Total: 74 Census payor type: Medicare: 19 Other: 55 Total: 74 Sample: 11 Residential Sample: 7 These deficiencies reflect state findings cited in	F0000	The submission of this plan of correction does not indicate an admission by Greenleaf Health Campus that the findings and allegations contained here in are accurate and true representations of the quality of care and services provided to the residents of Greenleaf Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an n economic and efficient manner. The facility here by maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirement governing the management of this facility. It is submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	accordance with 410 IAC 16.2. Quality review 8/24/11 by Suzanne Williams, RN			
F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to provide 1:1 activities for 2 of 10 residents reviewed for 1:1 activities on a sample of 11. (Residents #15, #27) Findings include: 1. Resident #15's record was reviewed on 8/16/2011 at 10:12 A.M. Resident #15's diagnoses included but were not limited to dementia, high blood pressure, and depression. In a continuous observation on 8/15/2011 between 9:45 A.M. and 11:50 A.M., Resident #15 was in her room sleeping with no music or television, then at 10:45 A.M. was gotten up in her wheel chair, taken to the nurse's station and placed at the station away from the television. During this time, she attempted to move her wheelchair without much success away from the area and asked to be pushed in her wheelchair.	F0248	Resident #15 and #27 have been assessed and no ill effects were noted. 1:1 activities have been updated for these residents. 08/23/11 2. All residents have been screened to determine which residents would benefit from updated 1:1 activities. In servicing from Home Office Activity Specialist was completed on 08/23/11, to Activity Assistants and Activity Director regarding 1:1 activity methods and documentation.. 3. Supplies were purchased for new 1:1 sensory and tactile items on 08/29/11. 1:1 activities are assigned to activities assistants daily. A communication log for possible 1:1 activities that other line staff can use when activities is not available will be started and nursing will be orientated to this by 09/10/11. 4. Activity Director or designee will check weekly to ensure all 1:1 activities have occurred. Quality Assurance committee will evaluate process 1x monthly x 3 months to ensure 95% compliance of weekly activities have been achieved and then the committee will decide to continue monitoring or if issue is	09/10/2011

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	During a continuous observation on 8/16/2011 between 9:32 A.M. and 11:30 A.M. Resident #15 was up in her high back wheel chair in the resident lounge sleeping in front of the television. No interaction was attempted by staff. Review of Resident #15's care plan dated 12/10/10, indicated she enjoyed arts and crafts, talking to others and hearing or reading the bible. Review of Resident #15's 1:1 activity log indicated Resident #15's activity for 8/16/11 was to visit the resident lounge. An interview with the Activity Director, on 8/17/2011 at 10:22 A.M., indicated Resident #15 was sleeping most of the day on 8/16, so no 1:1 activities were attempted. The Activity Director further indicated the staff could always put on music in her room. 2. Resident #27's record was reviewed on 8/15/2011 at 10:30 A.M. Resident #27's diagnoses included, but were not limited to, stroke, anxiety, and chronic pain. In a continuous observation on 8/15/2011 between 9:45 A.M. and 11:51 A.M., Resident #27 was in her room sleeping with no music or television.		resolved.5. 09/10/11.	

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	During a continuous observation on 8/16/2011 between 9:30 A.M. and 11:30 A.M., Resident #27 was in her bed sleeping, and no music or television was on. During a continuous observation on 8/16/2011 between 1:35 P.M. and 2:30 P.M. Resident #27 was in her bed sleeping; no music or television was on. Review of Resident #27's activity assessment dated 12/7/2010 indicated she enjoyed music and talking books. Activity notes dated 5/17/2011 indicated Resident #27 sleeps most of the time and activity staff will continue to attempt 1:1 visits. An activity note dated 8/9/2011 indicated Resident #27 sleeps through attempts at 1:1 visits. Review of Resident #27's 1:1 activity log indicated Resident #27's activity for 8/16 was music in the room. Talking books had not been attempted in the month of August. An interview with the Activity Director, on 8/17/2011 at 10:22 A.M., indicated Resident #15 was sleeping most of the day on 8/16, so no 1:1 activities were attempted. The Activity Director further indicated the staff could always put on music in her room.			

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	In an interview on 8/16/2011 at 2:00 P.M. CNA #1 indicated activity staff had not asked the staff to put music or the TV on for Resident #27. A current undated policy provided by the activity director on 8/17/2011 at 11:17 A.M. indicated at risk individuals should be provided enhanced programming to maintain quality of life. Additionally, the policy indicated if a 1:1 can not be completed as scheduled, the task must be carried over to the next appropriate day. 3.1-33(a)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure hot water temperatures for two of the three hallways were safe, under 120 degrees Fahrenheit. This potentially affected 33 of the 43 residents who were housed on the health care side of the facility. Findings include: 1. During the environmental tour of the facility, conducted on 08/15/11 between 9:45 A.M. - 11:30 A.M., with the	F0323	F-323 The mixing valve thermostat was reset immediately on 08/15/11. No ill effects were noted to any residents. No other residents were affected. Boiler output temp. and two random rooms will have temperature checked 5 out 7 days a week and documented on a log. The Maintenance Director and or there designee will be responsible for checking the temps 5 out of 7 days a week. The Executive Director will check weekly to	09/05/2011

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	Corporate Environmental Supervisor, Employee #5 and the facility's housekeeping supervisor, Employee #15, the hot water temperatures in Resident room #311 was noted to be 129.6 degrees. The hot water temperature in Resident room #312 was noted to be 128.6 degrees. Employee #5 then indicated all of the hot water for the health care side of the facility ran through one mixing valve. The mixing valve thermostat was then observed, and interview with Employee #5 indicated the mixing valve had been set on 128 degrees Fahrenheit. Employee #5 then left the environmental tour so he could correct the hot water issue. Hot water temperature in Resident room #201 was 123.5 degrees and the hot water temperature in Resident room 207 was 125.1 degrees. The hot water temperatures on the 100 hall were noted to be between 115 - 116 degrees Fahrenheit. Interview with Employee #5, on 08/14/11 at 2:00 P.M., indicated the facility was currently without a maintenance director and for some unknown reason, the mixing valve had been set too high. He indicated he had turned the mixing valve thermostat setting down and ran hot water out of the line until acceptable temperatures were		ensure the temps are being logged correctly. Quality Assurance will review monthly x 3 to ensure 95% complience with room temps. and Quality Assurance Team will decide by logs and values whether to continue in QA or not. 09/05/11.	

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	obtained. Review of the hot water temperature log, for the months of June, July, and August 2011 indicated the hot water temperatures, which had been done weekly instead of on a daily basis, were all within the safe temperature range. Employee #5 indicated he had been completing the hot water temperature logs since the previous maintenance director had left in the middle of July 2011. 3.1-45(a)(1)			
F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to provide interventions and monitor weight loss for 1 of 6 residents reviewed with weight loss in a sample of 11. (Resident #15) Findings include:	F0325	F-325 1. Resident #15 is being monitored by Licensed staff and all interventions are being followed. The resident is on weekly weights x 4 weeks and the Clinically at Risk Team will evaluate for need to continue or not. 2. The Director of Nurses and/or her Designee has looked at weights to ensure no other residents have been affected. 3.	09/10/2011

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	Resident #15's record was reviewed on 8/16/2011 at 10:12 A.M. Resident #15's diagnoses included, but were not limited to, dementia, high blood pressure, and depression. Resident #15's weights were recorded as follows: February 6, 2011 was 136.4. March 6, 2011 was 128 May 1, 2011 was 118.4 June 5, 2011 was 115 July 5, 2011 was 114 and August 6, 2011 was 104 No weight was available for April 2011. Interventions ordered by the physician on 3/20/2011 for the March weight loss was to begin 2 cal supplement. The nursing intervention was to begin additional foods high in protein. There were no interventions or documentation to indicate the dietician had reviewed Resident #15's weight loss between March and June. On June 5, 2011 the dietician reviewed Resident #15 and ordered an increase in 2 cal supplement to three times per day. In July, the dietician reviewed the weight loss and added magic cup. Resident #15 was placed on the "Clinically at Risk" review as well in July. August review by the Clinically at Risk committee indicated to continue to encourage intake. Speech therapy began as well and was reviewing		Clinically at Risk meetings will be Held weekly. Registered Dietitian will look over weights and document any recommendations for any weight losses 5% or greater weekly or as needed.4. The Director of Health Services and Or her designee will monitor weekly during Clinically at Risk meetings. The Quality Assurance Committee will receive a monthly report on how system is working x 3 months and if 95% complience on monthly report of weight losses >5% is obtained then the QA team will decide to continue monitoring or if that issue is resolved.5. 09/10/11	

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	texture and techniques to assist with increasing intakes. Resident #15 was not placed on weekly weights. In an interview on 8/17/2011 at 9:05 A.M. the Director of Nursing indicated the dietician receives a weekly report of weight losses in the building and Resident #15's weight loss should have been addressed in April and May. A current undated policy titled Guidelines for Weight Tracking indicated "...3. The facility dietician will review the resident's nutritional status, ideal body weight and current weight to implement a nutritional program when warranted...." 3.1-46(a)(1)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to maintain clean air vents and hand washing sinks in the kitchen area. This had the potential to affect 43 of 43 residents residing and receiving meals from the kitchen in the facility.	F0371	F-371 1. The hand washing sink and back splash by ice machine was cleaned on 08/14/11. The sink by dish machine and back splash were also cleaned that day. The ceiling air vents by the two compartment sink and by dish machine were cleaned that night. 08/14/11.2. Areas were	09/10/2011

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	Findings include: Current resident census provided by the Interim Administrator on 8/14/2011 at 6:00 P.M. indicated the census was 43, with no residents on tube feedings. During kitchen observation on 8/14/2011 at 4:03 P.M., the hand washing sink next to the ice machine was noted to have gray flaky particles in the sink and on the backsplash. During kitchen observation 8/14/2011 at 4:06 P.M. the hand washing sink by the dish machine was noted to have a sign taped to the back splash. The sink and sign had gray flaky particles on the backsplash and in the sink. In an interview on 8/14/2011 at 4:03 P.M. cook #3 indicated the sinks are cleaned each night, that a lot of people had been in that day and the sinks were dirty. In an interview with the Dietary Manager on 8/15/2011 at 12:15 P.M. he indicated the sinks should have been cleaned daily and there was no schedule to clean, but he would be sure it was corrected. During kitchen observation on 8/14/2011 at 4:06 P.M. ceiling air vents by the two compartment sink, over the serving and		cleaned so other residents would not be affected. 3. The hand washing sinks by ice machine and by dish washer are on a daily cleaning list. The ceiling air vents have been put on a monthly cleaning schedule. An in-service has been completed on the new cleaning schedule. 09/05/11.4. The Food Service Director and/or his designee will monitor daily 5 out of 7 days a week. The Quality Assurance Committee will discuss audit findings and when 95% complience is accomplished results will be discussed in Quality Assurance meeting monthly x 3 months then evaluate need to continue thru QA or issue resolved. 5. 09/10/11.	

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	preparation area, and by the dish machine over the clean dish area were noted to have gray feathery particles. In an interview on 8/14/2011 at 5:15 P.M. the Assistant Dietary Manager indicated the vents had not been cleaned once since he had been employed by the facility the last 5 months. In an interview with the Dietary Manager on 8/15/2011 at 12:15 P.M. he indicated there was no current schedule to clean the air vents in the kitchen, but a schedule would be made. 3.1-21(i)(3)			
R0000	The following State Residential findings are cited in accordance with 410 IAC 16.2-5.	R0000	The submission of this plan of correction does not indicate an admission by Greenleaf Health Campus that the findings and allegations contained here in are accurate and true representations of the quality of care and services provided to the residents of Greenleaf Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an n economic and efficient manner. The facility here by maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end,	

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			this plan of correction shall serve as the credible allegation of compliance with all state and federal requirement governing the management of this facility. It is submitted as a matter of statue only.	
R0119	(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the	R0119	R-119 1. Employee # 8 and	09/10/2011

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	facility failed to ensure the personnel files for 2 of 11 employees reviewed contained specific orientation for direct care givers. (Employee # 7, #8) Findings include: The personnel files were reviewed, on 08/17/11 between 9:30 A.M. - 11:15 A.M.. The personnel file for Employee #8, a certified nursing assistant, indicated she was hired on 05/29/10. There was no job specific orientation documentation located in her employee file. The personnel file for Employee #7, a CNA hired on 05/11/11, indicated the job specific orientation form, located in her personnel file was blank and not signed as complete. Interview with Employee #4, the Human Resource director responsible for maintaining the personnel files indicated she had recently been hired and was trying to implement a more organized system to ensure all of the orientation documentation was completed and maintained. She indicated both employees should have had a job specific orientation completed. A facility policy regarding job specific orientation documentation was requested on 08/17/11 at 1:30 P.M., but there was		employee # 7Have had their job specific orientation checklist completed.2. All employee files will be audited to Ensure all job specific orientation checklists have been completed.3. Business office manager and or herDesignee will audit all new hires to ensure all job specific checklists have been completed. 4. The Quality Assurance Committee will Review any audit findings monthly x 3 months then if 100% complience is accomplished the team will discuss whether to continue thru QA or that issue is resolved.5. 09/10/11	

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	no documentation provided prior to the exit from the facility on 08/17/11 at 3:30 P.M.			

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R0121	(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure there was	R0121	1. Employee #7 will be set up for a 1st and 2nd stepmantoux. Unable to do employee no longer	09/10/2011

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	155783	A. BUILDING 00 B. WING	08/17/2011

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	documentation 2 of 11 new employees had had a second step Tuberculin skin test. (Employee #7 and # 6) Findings include: During review of the personnel files, conducted on 08/17/11 between 9:30 A.M. - 11:15 A.M., the following was noted: Cook #6, hired on 08/11/10 did not have a second step Tuberculin skin test documented as completed until 01/6/11, almost 9 months after she started working. Certified Nursing Assistant #7, hired on 05/11/11, indicated there was no documentation a second step Mantoux test had been completed for her. Interview with Employee #4, the Human Resources director indicated prior to her employment, an audit had been completed and some of the missing documentation for personnel files had been "re-done" at that time and she felt that was probably why the second step for Employee #6 was completed so late. She indicated she had sent Employee #7 several notices regarding the need for a second step Mantoux, but the employee had not completed the test.		employed here.2. All employee files have been auditedto ensure all mantoux's are correct and current in files.3. The Human Resource person will havea tracking form to keep track of when newemployees hired and when they are due for amantoux.4. The Business Office Manager and or theirdesignee will audit all new hires within two weeks of hire to ensure step 2 mantoux has been completed timely. Quality Assurance will discussaudit findings monthly x 3 months and if 100% complience is accomplished then they will decidewhether to continue to monitor or issue resolved.5. 09/10/11	

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	Review of the facility's employee handbook, dated as revised on November 2007 indicated the following: "...PPD: A PPD (Tuberculin Mantoux skin test) test is required to be completed prior to an employee's first day of work." There was no instructions regarding a second step "PPD" test but the facility's documentation form had documentation for a second step Mantoux test. Again, there was no specific instructions regarding the time frame for obtaining the second step Mantoux testing, just instructions with a time frame for having the Second step PPD read.			
R0154	(k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observations and interviews, the facility failed to ensure 2 of 2 ceiling vents, the meat slicer, and the standing mixer were clean in the Residential kitchen. This had the potential to affect 31 of 31 residential residents who resided in the facility. Findings include:	R0154	R-154 1, The two ceiling vents one over the Clean dish side of the dishwashing Machine line and one located outside Dry storage room were cleaned that night. The meat slicer and standing mixer was cleaned that night. 2. An in-service has been completed on the Proper cleaning of meat slicer and standing mixer before putting them away if they are used. 3. Director of Food Services and or his Designee will	09/10/2011

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	During a sanitation tour of the facility's Residential kitchen, conducted on 08/15/11 between 1:45 P.M. - 2:30 P.M., the following was noted: Two ceiling vents, one located over the clean dish side of the dishwashing machine line and one located just outside the dry storage room were noted to have a heavy accumulation of dust. Interview with employee #9, the Food Service Supervisor (FSS), indicated he had only been in the facility for 3 weeks and he was thinking it was possibly a maintenance issue. The meat slicer, covered and put away as clean had visible dark colored residue along the underside of the slicing blade. The top of the blade and round the handle was noted to have a greasy feel to it. The standing mixer, covered and put away as clean, had yellow splatters around the place where the paddles were connected to the machine. Also the outside of the stainless steel bowl felt gritty and greasy. Employee #9, the FSS indicated he was unsure if the facility even utilized the machines anymore. He indicated some kitchen staff preferred to cook in the Residential kitchen and some kitchen staff prepared the food in the Healthcare kitchen and carted the food to the Residential kitchen to serve. He indicated the only food routinely prepared in the		check these items once a month to ensure they are stored away properly. 4. The Director of Food Services or his Designee will monitor cleaning audits monthly for Compliance and will take to Quality Assurance meetings monthly x 3 and when 100% complience is obtained, the committee will decide to continue to take thru QA or that issue is resolved with current system. 5. 09/10/11	

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	Residential kitchen was the short order breakfast foods.			